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HOUSE BILL 2458
By Fowlkes

AN ACT to amend Tennessee Code Annotated, Title 29, Chapters 20 and 26; Title 56; and Title 56, Chapter 32, relative to review of and liability for certain health care treatment decisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 29, Chapter 26, is amended by adding the following as a new part to be appropriately designated:

Section 29-26-__01. In this part,

(1) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

(4) "Health care provider" means a person or entity who delivers health care services to a Tennessee resident.

(5) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and a

decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees.

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and sickness insurance under Title 56 of this code.

(7) "Health maintenance organization" means an organization licensed to provide such services by the State of Tennessee.

(8) "Managed care entity" means any entity which delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by the state board of pharmacy.

(9) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the laws of this state or a non-profit health corporation doing business in the state of Tennessee; or

(C) another person wholly owned by physicians.

(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization, or managed care entity, that degree of care that a health insurance carrier, health maintenance organization or managed care entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance

organization, or managed care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances.

Section 29-26-_____.02. (a) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

(1) employees;

(2) agents;

(3) ostensible agents; or

(4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

(1) neither the health insurance carrier, health maintenance organization, or other managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurance carrier, health maintenance organization, or other managed care entity is liable under

subsection (b), controlled, influenced, or participated in the health care treatment decision; and

(2) the health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.

(e) This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the state board of pharmacy that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurance carrier, health maintenance organization, or managed care entity may not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurance carrier, health maintenance organization, or other managed care entity may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(h) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by such health

insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurance carrier, health maintenance organization, or managed care entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or managed care entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

(j) This chapter does not apply to workers' compensation insurance coverage as defined in title 50 of this code.

(k) An enrollee who files an action under this part shall comply with the requirements of this title as it relates to cost bonds, deposits, and expert reports.

Section 29-26-____03. (a) A person may not maintain a cause of action under this part against a health insurance carrier, health maintenance organization, or other managed care entity that is required to comply with the utilization review requirements of any other provision of law, unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization, as required by subsection (c).

(b) The notice required by subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or managed care entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the claim is made requests the review not later than the 14th day after the date notice under subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or managed care entity. If the health insurance carrier, health maintenance organization, or managed care entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) Subject to subsection (e), if the enrollee has not complied with subsection (a), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed thirty (30) days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with subsection (a).

(e) The enrollee is not required to comply with subsection (c) and no abatement or other order pursuant to subsection (d) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed

care entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct it is liable under 29-26-___02(b); and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after hearing that such pleading was not made in good faith, in which case the court may enter an order pursuant to subsection (d).

(f) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by subsection (a), before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until the later of:

(1) the thirtieth (30th) day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the fortieth (40th) day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under subsection (a)(2)(A).

(g) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 32, is amended by adding the following as a new part:

(a) The procedures for appeals relative to managed care organization liability shall be reasonable and shall include the following:

(1) a provision that an enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care provider may appeal the

adverse determination and shall be provided, on request, a clear and concise statement of the clinical basis for the adverse determination;

(2) a list of documents needed to be submitted by the appealing party to the utilization review agent for the appeal;

(3) a provision that appeal decisions shall be made by a physician, provided that, if the appeal is denied and within ten (10) working days the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the adverse determination;

(4) in addition to the written appeal, a method for an expedited appeal procedure for emergency care denials and denials of continued stays for hospitalized patients, which shall include a health care provider who has not previously reviewed the case; such appeal must be completed no later than one working day following the day on which the appeal, including all information necessary to complete the appeal, is made to the utilization review agent; and

(5) written notification to the appealing party of the determination of the appeal, as soon as practical, but in no case later than the thirtieth (30^{th}) day after the date the utilization agent receives the appeal. If the appeal is denied, the written notification shall include a clear and concise statement of:

(A) the clinical basis for the appeal's denial

(B) the specialty of the physician making the denial; and

(C) notice of the appealing party's right to seek review of the denial by an independent review organization and the procedures for obtaining that review.

(c) Notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an independent review organization and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination. For purposes of this section, "life-threatening condition" means a disease or other medical condition with respect to which death is probable unless the course of the disease or condition is interrupted. A utilization review agent shall:

(1) permit any party whose appeal of an adverse determination is denied by the utilization review agent to seek review of that determination by an independent review organization assigned to the appeal as provided by law;

(2) provide to the appropriate independent review organization not later than the third business day after the date that the utilization review agent receives a request for review a copy of:

(A) any medical records of the enrollee that are relevant to the review;

(B) any documents used by the plan in making the determination to be reviewed by the organization;

(C) the written notification as prescribed herein;

(D) any documentation and written information submitted to the utilization review agent in support of the appeal; and

(E) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal;

(3) comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee; and

(4) pay for the independent review.

SECTION 3. Tennessee Code Annotated, Section 56-32-210, is amended by adding the following as a new subsection to be appropriately designated.

Section 56-32--___.

(b) The commissioner of commerce and insurance may examine the complaint system. The complaint system required by this act must include:

(1) notification to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization;

(2) notification to the enrollee of the procedures for appealing an adverse determination to an independent review organization; and

(3) notification to an enrollee who has a life-threatening condition of the enrollee's right to immediate review by an independent review organization and the procedures to obtain that review.

(c) The provisions of this title that relate to independent review apply to a health maintenance organization under this section as if the health maintenance organization were a utilization review agent.

SECTION 4. (a) The commissioner of commerce and insurance shall:

(1) promulgate standards and rules for:

(A) the certification, selection, and operation of independent review organizations to perform independent review described.

(B) the suspension and revocation of the certification;

(2) designate annually each organization that meets the standards as an independent review organization;

(3) charge payors fees in accordance with this article as necessary to fund the operations of independent review organizations; and

(4) provide ongoing oversight of the independent review organizations to ensure continued compliance with this article and the standards and rules adopted under this article.

(b) The standards required by subsection (a)(1) of this section must ensure:

(1) the timely response of an independent review organization selected under this article;

(2) the confidentiality of medical records transmitted to an independent review organization for use in independent reviews;

(3) the qualifications and independence of each health care provider or physician making review determinations for an independent review organization;

(4) the fairness of the procedures used by an independent review organization in making the determinations; and

(5) timely notice to enrollees of the results of the independent review, including the clinical basis for the determination.

(c) The standards adopted under subsection (a)(1) of this section must include standards that require each independent review organization to make its determination:

(1) not later than the earlier of:

(A) the fifteenth (15^{th}) day after the date the independent review organization receives the information necessary to make the determination; or

(B) the twentieth (20th) day after the date the independent review organization receives the request that the determination be made; and

(2) in the case of a life-threatening condition, not later than the earlier of:

(A) the fifth (5th) day after the date the independent review organization receives the information necessary to make the determination; or

(B) the eighth (8th) day after the date the independent review organization receives the request that the determination be made.

(d) To be certified as an independent review organization under this article, an organization must submit to the commissioner an application in the form required by the commissioner. The application must include:

(1) for an applicant that is publicly held, the name of each stockholder or owner of more than five percent (5%) of any stock or options;

(2) the name of any holder of bonds or notes of the applicant that exceed one hundred thousand dollars ($100,000);

(3) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control;

(4) the name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under subdivision (3) of this subsection and a description of any relationship the named individual has with:

(A) a health benefit plan;

(B) a health maintenance organization;

(C) an insurer;

(D) a utilization review agent;

(E) a nonprofit health corporation;

(F) a payor;

(G) a health care provider; or

(H) a group representing any of the entities described by Paragraphs (A) through (G) of this subdivision;

(5) the percentage of the applicant's revenues that are anticipated to be derived from reviews conducted under of this act;

(6) a description of the areas of expertise of the health care professionals making review determinations for the applicant; and

(7) the procedures to be used by the independent review organization in making review determinations with respect to reviews conducted under this act.

(e) The independent review organization shall annually submit the information required by subsection (d) of this section. If at any time there is a material change in the information included in the application under subsection (d) of this section, the independent review organization shall submit updated information to the commissioner.

(f) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a payor or a trade or professional association of payors.

(g) An independent review organization conducting a review this act is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

SECTION 9. The provisions of this act apply only to a cause of action that accrues on or after the effective date of this act. An action that accrues before the effective date of this act is

governed by the law applicable to the action immediately before the effective date of this act, and that law is continued in effect for that purpose.

SECTION 10. The change in law made by this act applies only to an adverse determination of a utilization review agent or health maintenance organization made on or after the effective date of this act.

SECTION 11. This act takes effect July 1, 1998, the public welfare requiring it.